This presentation was provided as a Webinar for Health Home Care Coordinators which aired on July 9, 2015. Review of this PowerPoint presentation satisfies, in part, the required State-sponsored special training modules for Health Home Care Coordinators.

Opening comments:
-Hello everyone welcome to Cultural and Disability Competence Webinar. My name is Roseann Martinez and I am the Quality Assurance Contract Specialist for Health Homes at DSHS.

My most recent work before coming to DSHS in January of 2015 was as an instructor of social work at UW Tacoma and Pacific Lutheran. Among the courses I taught was Cultural Diversity and Societal Justice, both at the bachelors and masters level. I believe diversity training is most effective when it is interactive and experiential and that the webinar format is very limited.

In today's presentation we will discuss the definition and role of culture, we will consider multicultural issues in family, communication and help seeking. And I will present some thoughts on the process of becoming culturally competent.
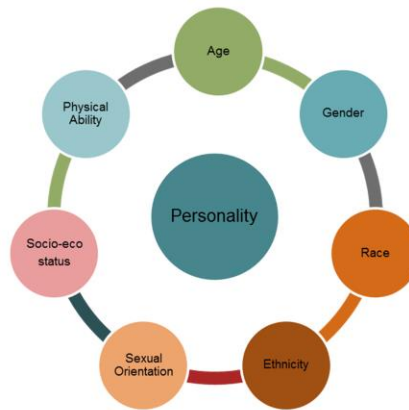
Culture refers to

- Integrated patterns of human behavior language
  - thoughts
  - communications
  - actions
  - beliefs
  - values
  - institutions
  of racial, ethnic, religious, or social groups.
- Traditions and understandings passed on from generation to generation.
- Shared interpretation of experience by like groups.

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Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, beliefs, values and institutions the group's members hold.

We are socialized and experience traditions and our understanding of the world through the voices and messages that are passed on through generations.

We tend to interpret how we experience the world through the lens in which we were raised or through the lens of the groups we share membership.
That is true for ourselves and for the people we serve.

Let's look at the internal dimensions of culture. We are all complex cultural beings, not just made up of our race but of many characteristic and this illustration points out a few of them. Each of us, at our core, has our inner most being, for these purposes today, our personality.

And we are members of groups assigned to us, some by our culture and some by self assignment. These shape who were are in this present moment. Parenthetically I will add that this way of viewing ourselves, is embedded in the social construct of our current times in these United States.

I suggest, we are grouped or identify ourselves by these….our age, gender, race, ethnicity, sexual orientation, socio-economic status, physical ability…..to name a few. Some of our group memberships can change, for example our age changes as do our physical abilities.
Our values established through these group memberships can vary from person to person. Becoming deaf later in life could be experienced by us as a disability, yet someone deaf from birth may have a deep identification with deaf culture and their deafness is not something to be fixed.

I have a good friend, a social worker, who is deaf as is her partner. When her child was born it was reported to her triumphantly, "your baby can hear!!" That was a grave dismissal of her culture…one might call this a micro-aggression.

Micro-aggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. In many cases, these hidden messages may invalidate the group identity or experiential reality of target persons, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten and intimidate or relegate them to inferior status and treatment.

While micro-aggressions are generally discussed from the perspective of race and racism any marginalized group in our society may become targets: people of color, women, LGBT persons, those with disabilities, and religious minorities, to name a few.

Some examples of micro-aggressions and their hidden meaning include:

Racial Micro-aggressions:
• A White man or woman clutches their purse or checks their wallet as a Black or Latino man approaches or passes them. (Hidden message: You and your group are criminals.).
• An Asian American, born and raised in the United States, is complimented for speaking "good English." (Hidden message: You are not a true American. You are a perpetual foreigner in your own country.)
• I am Mexican, and I am often asked where are you from…..really the hidden question is "I really can't place your brownness, what's your ethnicity?" Which I feel could be a kind question. Yet I am often confused by "where are you from?" "Tacoma?"

Gender Micro-aggressions:
• An assertive female manager is labeled as a "bitch", while her male counterpart is described as "a forceful leader". (Hidden message: Women should be passive and allow men to be the decision makers.)
• A female physician wearing a stethoscope is mistaken as a nurse. (Hidden message: Women should occupy nurturing and not decision-making roles. Women are less capable than men).
• Whistles or catcalls are heard from men as a woman walks down the street. (Hidden message: Your body/appearance is for the enjoyment of men. You are a sex object.)

Sexual Orientation Micro-aggressions:
-A Young person uses the term "gay" to describe a movie that she didn't like. (Hidden message: Being gay is associated with negative and undesirable characteristics.)
• Two gay men hold hands in public and are told not to flaunt their sexuality. (Hidden message: Same-sex displays of affection are abnormal and offensive. Keep it private and to yourselves.)

Making assumptions that someone's partner should be of the opposite sex.

Other types of Micro-aggressions, including using particular groups to categorize someone's behavior.

When bargaining over the price of an item, a store owner says to a customer, "Don't try to Jew me down." (Hidden message: Jews are stingy and money-grubbing.)
• A blind man reports that people often raise their voices when speaking to him. He responds by saying, "Please don't raise your voice; I can hear you perfectly well." (Hidden message: A person with a disability is defined as lesser in all aspects of physical and mental functioning).
• The outfit worn by a TV reality-show mom is described as "classless and trashy." (Hidden message: Lower-class people are tasteless and unsophisticated.)
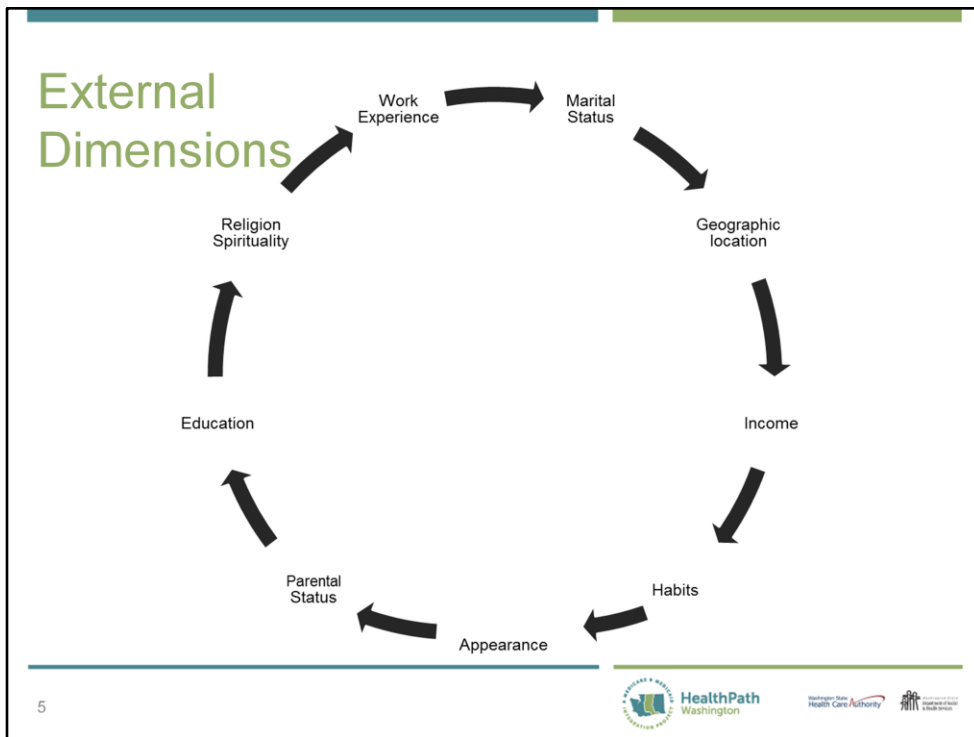
We also have some external dimensions of roles and groups that we are a part of which influence how we view ourselves and others, how decisions are made and what resources and tools are used to make those decisions. There is work experience, marital status, geographic location, income, habits, appearance, parental status, education, and religion/spirituality.
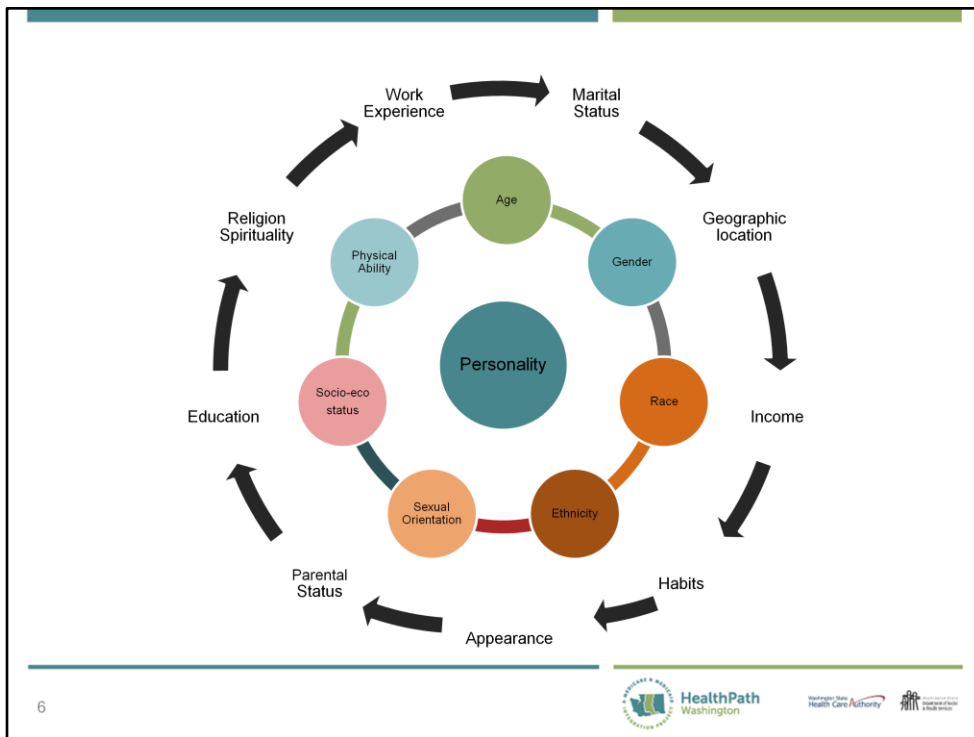
This is just one model, not meant to be exclusive or inclusive, it is a way to illustrate the complexity of all of us, equally those we serve. Our clients are very unique, our clients are part of multiple groups therefore having a cookie cutter approach based on generalities for one group is very problematic and can lead us down a path that can do harm and corrupt our efforts to reduce social distance. Herein lies one of my aims, which is to reduce social distance between me and others, those around me and those I serve.

These dimensions have shaped our socialization. We have a set of values that we have learned because of our membership in these groups. We have heard messages from society about us because of these group memberships.

Role of Culture Dictates:

- Health, healing and wellness beliefs
- How illness is perceived and caused
- Attitudes toward providers and treatment
- How problems are defined

The role of culture in our work is very important. Culture, cultural values, beliefs and traditions significantly affect the understanding of health and individuals with chronic conditions. Client's dynamic cultural essence will influence their health, healing and wellness beliefs. They will have a certain understanding of how illness is perceived and caused, culture will influence their attitudes toward providers and treatment and overall how health problems are defined.

If you know the book , *The Spirit Catches You and You Fall Down*, basically the book tells the story of a family's favored daughter who has severe epilepsy and the culture conflict that obstructs her treatment. The book explores the dichotomy between the Hmong's perceived spiritual factors and the Americans perceived scientific factors in addressing epilepsy.

There are some vast generalities about different cultural groups that can be informative, yet there is no substitute for asking good questions, listening and looking at your surroundings. For instance, in the Latino/Hispanic culture commitment to home and folk remedies may be more pronounced among newer immigrants. More acculturated Latinos may be very integrated into Western medicine.

One might think immediately that interpretation services may be needed but that isn't always the case. Don't make assumptions about language until you know for sure of the needs.

Role of Culture Influences

- How individuals and families cope with stress
- Determines if and when help is sought by "outsiders"
- The expectations one has of others
- Degree of disclosure, cooperation and trust

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The role of culture influences our response to daily interactions with our surroundings, feelings and people.

Culture influences how individuals and families cope with stress.

Culture influences how and when people will seek help from "outsiders".

Culture influences the expectations one has of those around them, other family members as care givers, and expectations of medical personnel.

Also culture influences the degree of self-disclosure and engagement and the level of cooperation and trust.

In the next few moments we are going to take a broad view of cultural considerations in relationship to family, disclosure and engagement, and how people seek help.

Family Roles

- Who is expected to provide care to frail members? What happens when they fail?
- Who makes decisions about how family resources are expended? About other aspects of family life?
- Who, within the family, do members turn to in times of conflict or strife?

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Cultural considerations in working with families it is important in order to get a handle on the roles, responsibilities, and voice of the family. Who is expected to provide care for the sick member and what happens if that person fails? Who makes decisions about family resources? Who within the family do members turn to in times of conflict or strife?

A very complex issue in considering family roles is determining the role of the person who is sick and how that may or may not disrupt the family dynamic.

Communication

- Information sharing
  - Oral
  - Written
  - Nonverbal
- Decision makers
  - Head of house
  - Religious leaders

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One must consider cultural influences on communication. This is very important for the purposes of disclosure and engagement.
One must consider oral communication which includes dialects, tone of voice and attitudes toward the interpreter if one is to be used.

When considering written communication it is important to be sensitive to literacy across all social and diverse groups. It is especially important for acquiring consent and who the client will let read sensitive information about them.

Nonverbal considerations are very important….attitudes about touch, hand shakes and eye contact can determine the extent to which one offends or at best has a door closed for further assessment.

We discussed decision makers in the previous slide though understanding the decision maker's role. This person could be the "head of the house". It could actually be the person who is sick. Religious leaders may also play a role in decision making. There is a whole area of cultural assessment related to spiritual and religious influences in a person's life.

Help Seeking

- Gatekeepers
- Cultural barriers
  - Limited English speakers
  - Low literacy
  - Immigration considerations
  - Laws
- Attitudes about illness
  - "shaming" or "face-saving"

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There are complexities to seeking help that are both personal and cultural. Understanding Gatekeepers as trusted sources of information in cultural community is critical, a care coordinator can actually fulfill that role by establishing a position of trust within the family/cultural group.

There are cultural barriers that prevent or challenge someone to seek help. English as a second language or low English comprehension and low reading levels can be barriers. Immigration considerations are extremely important, the need for help yet worries about being "found out" and deported can be paralyzing for some. Being uncertain about laws giving access to care can also add to these worries.

Overall stigmatization and attitudes play a part in accepting care. Being sick may be seen as weakness or thought of as bad. It may imply that you are a bad person or are being punished. It may reflect an attitude about illness as simply not wanting to bother anyone. One care coordinator described to me the challenges she sometimes faces when visiting older Latina/Mexican women. They often want to downplay their need for help. Even when or especially when the care coordinator is Latina herself.

Road to Competency

Perception of Culture

- Ethnocentrism –one's ethnic or cultural group is centrally important and that other groups are measured in relation to one's own
- Cultural Relativism –particular idea varies from one society or societal group to another

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As we begin to discuss competency and the process, journey and building blocks of cultural competency it is important to lay a theoretical framework in which culture is perceived.

Ethnocentrism is the tendency to believe that one's ethnic or cultural group is centrally important and that other groups are measured in relation to one's own.

Cultural relativism is a concept that a particular idea varies from one society or societal group to another. For instance a particular society or culture may have a perception of what is good/bad or right/wrong.

So this theory of cultural relativism can ground us in our work to be culturally competent.
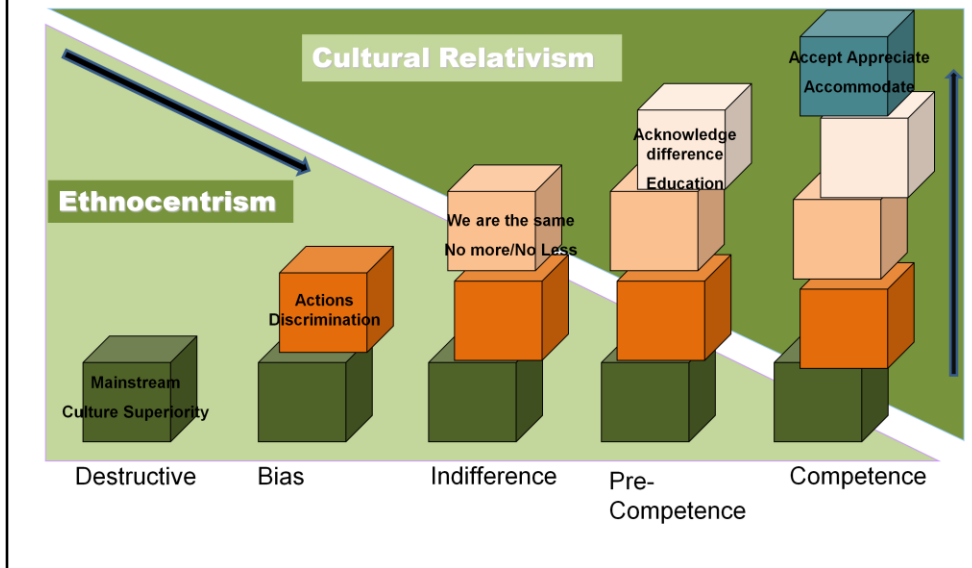
Cultural Competence

- A set of consistent behaviors, attitudes, skills and knowledge that create respectful interactions with people different from ourselves.
- Occurs on a continuum

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Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables work and services to be delivered effectively in cross cultural situations. Competence implies the capacity to function effectively.

And competency occurs on a continuum that isn't always linear. We often move forward and back along the continuum. I will talk about that in a few moments.

Cultural Competence

Cultural Relativism

Ethnocentrism

Accept Appreciate
Accommodate

Acknowledge
difference

Education

We are the same

No more/No Less

Actions
Discrimination

Mainstream
Culture Superiority

Destructive   Bias   Indifference   Pre-Competence   Competence

Ethnocentrism is the tendency to believe that one's ethnic or cultural group is centrally more important and that other groups are measured in relation to one's own. Imagine the ethnocentrism triangle taking up space in an imaginary line across the bottom of the line. As ethnocentrism decreases it give more room for the concept of cultural relativism to increase.

Cultural relativism is the concept that particular ideas and approaches to life vary from one society or societal group to another.

Along this continuum we are on a journey towards greater competency that includes five stages. We will now go through each one of these stages.

In the cultural destructiveness stage Multi-culturalism is viewed as a problem. The attitude of people in this stage is "if all can be mainstreamed our society would be better". And if "other" cultures can be suppressed or destroyed society will be better off. Therefore, it is ok to suppress or destroy other cultures.

Destructiveness also assumes that one culture is more superior and should work at eradicating other cultures. At this end of the continuum are the white supremacy groups or the religious radicals.

In this next stage of the continuum people lack cultural awareness and culturally competent skills and sensitivities.

People in this stage may have been brought up in a homogenous society and been taught to behave in certain ways and have never questioned it.

They believe in superiority of a dominant group and assume a paternalistic posture towards others.

In this stage stereotypes are maintained and discriminatory actions are maintained.

Cultural Indifference

We are the same
No more/No Less
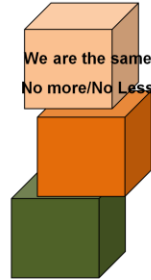
- See others in terms of their own culture.
- Believe that culture makes no difference.
- Believe that all people should be treated in the same way regardless of race, disability, status
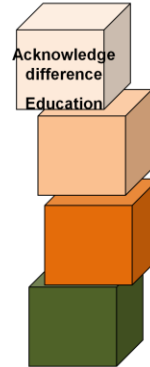
In this stage one sees others in terms of their own culture and claim that all people are exactly alike.

One believes that culture makes no difference and have the attitude that "We are the same."

In this stage it is believed that all people should be treated in the same way regardless of race, disability, or status.

In the Cultural Pre-competence stage it is recognized that there are cultural differences and one starts to educate themselves and others concerning differences in cultures.

One also realizes shortcomings in ignoring a diverse environment.

Yet it is sometimes easy to become complacent in their efforts at this stage.

Cultural Competence-Basic

- Accept, appreciate and accommodate cultural and disability differences
- Value diversity and accept and respect differences
- Accept the influence of their own culture in relation to other cultures
- Understand and manage the dynamics of difference when cultures and disability intersect

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Achieving cultural competency and being a multiculturally competent practitioner is a journey. It requires that we are open and that we approach the journey with humility and a little humor. Increasing our competency means we are able to communicate effectively across cultural boundaries
with sensitivity to the cultural differences and preferences involved on both sides of those boundaries.

Achieving multicultural and disability competency challenges an individual to know his or her own culture and the cultures of others and to employ that knowledge by engaging people of other cultures in mutually gainful communication.

When we employ our multicultural skills we recognize that a person's own way of thinking and behaving is not the only way. Because one recognizes that there are multiple paths to achieving goals, we are able to think and behave with flexibility. There is a sense that the world is a place inhabited by multiplicity and diversity and encourages people to be comfortable with differences in others.

Cultural Competence - Advanced

- Actively educate less informed individuals about cultural/disability issues
- Advocate for just systems
- Seeks knowledge
- Develop skills
- Become allies with and are comfortable with others

The advance cultural competent practitioner moves beyond accepting, appreciating, and accommodating cultural and disability differences and actively educates less informed individuals about cultural/disability issues.

In this stage one works to advocate for just systems.

One seeks out knowledge and develops skills to interact in diverse environments. In this stage one becomes allies with and is comfortable interacting with others in diverse settings.

In this stage there is tremendous growth in reducing social distance with others.
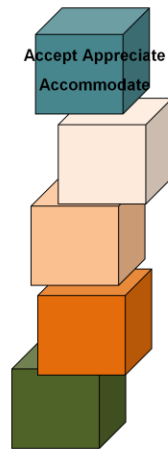
Using a model called FLEX, I want to give you with some thoughts around skill building to increase competency…..using the acronym FLEX.
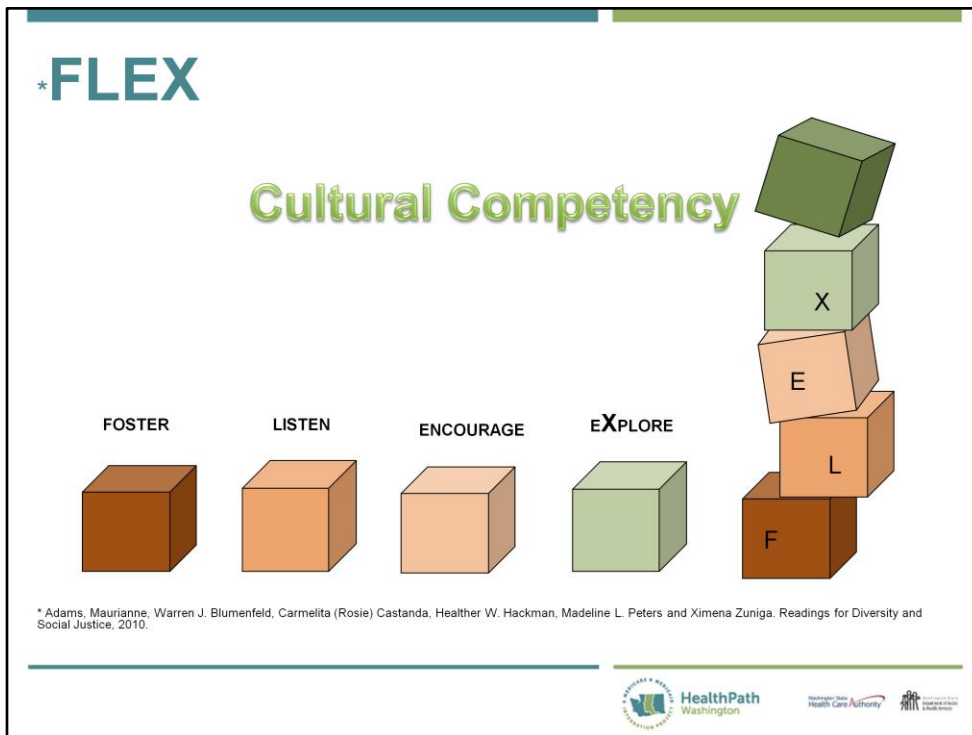
The FLEX model incorporates four building blocks for achieving cultural competency. The FLEX model was adapted from a training program offered through the Office of Training and Development at the University of Massachusetts Amherst and was developed by those referenced in the slide.

These building blocks are not re-enforced, there is no rebar. As individuals we have experiences, triggers or lapses of our core beliefs and we can tumble the blocks. We can shake or at worse topple the structure but we check ourselves, re-engage, self-assess and build again.

A trigger is something that an individual says or does or an organizational policy or practice that makes us, as members of social groups, feel diminished, offended, threatened, stereotyped, discounted or attacked. Triggers do not necessarily threaten our physical safety. We often feel psychologically threatened. We can also be triggered on behalf of another social group. Though we do not feel personally threatened, our sense of social justice is violated.

A good friend of mine is a chaplain in a hospital and when she went to visit a patient, the patient was ranting about Mexicans and said, "they should all be taken out and shot." For her that was a trigger. In the moment she couldn't serve that patient. She had to check herself, in this case remove herself from the situation and return later after she regained her composure.

FLEX

- **F**oster interconnectedness
  - Understand your own values, beliefs and practices
  - Explore commonalities
  - Assume the positive
  - Recognize humanity

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The F in FLEX is for Foster Interconnectedness. We are to recognize, accept, appreciate, accommodate and value diversity. We build respect for differences.
We are culturally self aware. We seek to develop one's own personal and cultural values and increase our appreciation of the importance of multicultural identities in the lives of our clients.

We function in accordance with the values of our profession and know how our personal values may conflict with the needs of diverse clients. Some of us may have strong religious beliefs that make it difficult to serve others. An example is the conflict that may arise in a women's right to choose and reproductive rights to a person's right to refuse certain types of treatment.

On an administrative level we can foster a work place that advocates the recruitment, hiring and retention of staff that reflect our diverse clients.

For example, one Care Coordination Organization has offered additional trainings on language colloquialism among the Spanish speaking in the Wenatchee Valley.

The L in FLEX is for Listen and communicate. We develop our listening skills. We can do homework and study to educate ourselves about particular cultures, but it is always important to listen to the individual and their story.

Social groups and strata may impact one's life.

We should work to understand others' frame of reference and communicate with our good non-judging hat.

Make sure we are stating our ideas clearly and constructively.

The E in FLEX stands for Encourage respect.   We understand and manage the dynamics of difference when cultures and disability intersect. We actively educate less informed individuals about cultural issues.

We respect the inherent dignity and worth of a person and work toward ending discrimination and oppression.

We ensure that we work toward eliminating barriers for our clients.

We use skills, approaches and techniques that reflect our understanding of the role of culture in the helping profession.

The X in FLEX is for eXplore differences. We develop skills and knowledge to interact in diverse environments. We become allies with and develop comfort in interacting with others in diverse settings. We increase our professional acumen.

We develop cross cultural knowledge by seeking ways to understand the history, traditions, values, family systems and artistic expressions of major client groups we serve.

We advocate and participate in educational and training programs that help advance cultural competence within our programs.

Action Steps

- Develop support for change
- Identify groups to be involved
- Identify barriers
- Assess current level of cultural competence
- Identify resources needed
- Develop goals
- Commit to an ongoing life long process

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These are some action steps to consider in becoming and increasing one's cultural competency.

Examine one's self, by asking how can I get the support I need to change and put on glasses with a different lens?

Perhaps we can find groups to be involved with that help reduce social distance or groups in which to learn about another culture.

Consider what might be your personal barriers and ask yourself, "how can I overcome them?"

EXAMPLE:

Consider my level of competence by examining the groups I am part of to increase my understanding of my values and how the groups I am a part of have shaped those values.

Identify the resource I need to attain goals I set.

And commit to an ongoing life long process of becoming culturally competent.

This webinar explored cultural and disability competency, increased one's understanding of the role of culture in health care, developed an understanding of the process of becoming culturally competent and encouraged the development of action steps.

Post Webinar Discussion

- Questions
- References
- Challenges
- Share their own culture
- Share examples of Health Home experiences

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Certificate of Completion

Cultural Competence Considerations

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Please sign and date this slide to attest that you reviewed this training PowerPoint

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